Advancing Trauma-Informed Practices

Bringing trauma-informed, resilience-focused care to children, adolescents, families, schools and communities.

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About the Authors

William Steele, PsyD, MSW is the Founder of The National Institute for Trauma and Loss in Children (TLC) established in 1990. Dr. Steele has had numerous publications in such journals as the *School Social Work Journal, Children and Schools, Residential Treatment for Children and Youth, National Social Sciences Associations, Reclaiming Children and Youth,* and publications with Guilford Press, American Counseling Association, and Allyn and Bacon.

Today, there are over 6,000 TLC Certified Trauma and Loss School and Clinical Specialists whom Dr. Steele has personally trained. Insistent that intervention for traumatized children be outcome driven, he developed and conducted evidenced-based research on TLC trauma specific programs for schools and communities. With its focus on early intervention, TLC's *I Feel Better Now!* program for children 6-12 years old, for example, is the only school-based, evidence-based program of its kind in the country. Of the numerous honors Dr. Steele has received over the years, he is most proud of the 6,000 Certified Trauma Specialists who are providing TLC interventions and resources to thousands of children, families, schools and communities daily, which never receive the national media attention they deserve.

Caelan Kuban, LMSW, CTC-S is Director of The National Institute for Trauma and Loss in Children (TLC), a program of the Starr Institute for Training. As a Certified Trauma Consultant-Supervisor, she provides trauma assessment and short-term trauma intervention for students utilizing trauma-informed and evidence-based practices including TLC's *SITCAP®* model. Caelan also provides training across the country to professionals working with traumatized children and families and has numerous publications in such journals as the *School Social Work Journal, Children* and *Schools,* and *Residential Treatment for Children and Youth*. Caelan is currently pursuing her doctorate in clinical psychology at Cal Southern University.

Actual Situations

- Abused, neglected and raped multiple times, 15-year-old "R" has become unmanageable.

- A mother and her 4-year-old son drive up to their garage. As the mother opens the garage door both are terrified by the body of the mother's fiancé hanging dead.

- Three siblings, ages 5, 11 and 15, are traumatized by the brutal rape and murder of their stepsister. One year later, all are involved in challenging and troublesome behavior.

- At age 2, James witnesses his father kill his mother. The only way he can fall asleep is to sleep on the floor.

- Taken from his mother at an early age, "J" is moved in and out of 15 different foster care homes.

- Twenty-four high school students witness the shooting and murder of their beloved coach. Months later, they and their parents are struggling at home and at school with intense fears, worries and emotions altering their relationships and ability to perform.

- A high school student stabs his teacher to death in the classroom. Parents, staff and students are overwhelmed.

These actual situations, and so many others, represent the kinds of traumatic experiences, varied levels of severity, complexity, diverse environments and developmental ranges of children, teens and adults who benefit from TLC's trauma-informed practices. TLC, a program of Starr Commonwealth and the Starr Institute for Training, began developing trauma-specific, evidence-based intervention strategies for practitioners in varied settings when it was founded in 1990 by Dr. William Steele.

The Purpose

The purpose of this paper is threefold:

1) To define the primary experience of trauma in order to support trauma-informed care grounded in evidence-based research, neuroscience and the essential components of trauma-informed practices,

2) To view trauma not as a diagnostic category but as a series of experiences that result in survival driven behaviors, thoughts, emotions, sensations and needs unique to trauma-tized children which are often misinterpreted and assigned as symptoms of disorders other than trauma, and

3) To explain the essential importance of understanding the child's experience, within a trauma-informed context, in order to guide practitioners in evaluating, identifying and initiating trauma-informed, developmentally appropriate interventions beneficial to the unique needs and world of traumatized children and youth.

The paper is intended for non practitioners seeking information about trauma and its impact on children and youth, practitioners new to the field of trauma, experienced prac-titioners who find cognitive behavioral approaches limited in their use and success with multiply traumatized children, for those evaluating available practices for helping victims better manage day-to-day functions and interactions and for helping them develop and or restore a renewed resilience as they learn to survive and flourish despite their experiences.

Terms and Treatments

Following is a list of terms and trauma treatment models frequently written about in trauma-focused articles and books. Being trauma-informed suggests that we ought to be able to discuss in detail the important role and value each plays in providing trauma-informed care and initiating trauma-informed practices. Research, science, associated history and examples that support the value of these terms and treatments will be included in our discussion. This is not an all inclusive listing but does begin to reflect the scope of what we know about childhood trauma today. These terms reflect just some of the factors needed to guide and support the care and treatment of traumatized children today. They also represent the advances in trauma treatment and why we, as practitioners and child service delivery systems, are being challenged to change the way we care for children today.

- Safety
- Choice
- Hyper-arousal
- Regulation
- Resilience
- Repressive coping
- Posttraumatic Growth (PTG)
- Trauma narrative
- Private logic
- Trauma-informed relationships and environments
- Trauma-informed assessment
- Trauma integration
- Implicit-explicit processes

- Thinking
- Feeling
- Survival brain
- Left and right hemispheres
- Amygdala
- Hippocampus
- Frontal cortex
- Broca's area
- Iconic symbolization
- Sensory integration
- Cortisol
- Oxytocin
- Epigenetics
- Developmental Trauma Disorder (DTD)

- Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)
- Eye Movement Desensitization Reprocessing (EMDR)
- Somatic Experiencing (SE)
- Sensorimotor Psychotherapy
- *Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP®)*
- Neurosequential Model of Therapeutics (NMT)
- Mindfulness

If we consider that each of these terms and treatment models involve additional characteristics and practice considerations specific to traumatized children who exhibit varied levels of severity, symptoms, weaknesses and strengths, different behaviors in different environments and having various levels of support, then we must ask ourselves, **"what matters the most in our efforts to help?"**

What Matters Most

What matters about how children cope with trauma is determined by how they experience what they are exposed to, who they were exposed to in their traumatic past, and who and what they are exposed to in their current environment.

Given all we know about trauma today, how traumatized children experience themselves, their environment, ourselves as practitioners and how they experience the world is what must guide us in our assessment, care of and treatment of traumatized children. This necessitates further explanation.

It is Not the Situation

An Internet search for trauma-informed care yields more than seven million references. It is safe to say that a great deal of information exists about the prevalence of trauma experienced by children and what constitutes trauma-informed care. The majority of articles regarding trauma consistently cite violence as the primary cause of trauma.   There is no doubt that violence does induce severe trauma in children. Most would agree that at least 50% of the children in child welfare and 60-70% of youth in the juvenile justice system experience trauma (Hodas, 2006 a). However, research began to emerge as early as the 1990s indicating that trauma can also be induced by such disasters as fires (McFarlane, 1994), hurricanes (Lonnigan et. al., 1991), boating accidents (Yule, 1992), burns and medical procedures such as bone marrow transplants (Stubner et. al., 1991). Three million people yearly are involved in car accidents; up to 45% of those injured suffer posttraumatic stress disorder (PTSD) (PTSD Support Services, 2011). In fact, divorce can also induce trauma when the conditions of that experience leave children vulnerable (PTSD Causes and History, 2011).

We have two reasons for making this distinction between violent and non-violent situations – situations that are not the result of direct intent to do harm. First, in comparison to the volumes written about the relationship between violence and trauma, rarely do we read about the daily non-violent situations inducing trauma in children. Often trauma is not screened for in children exposed to situations like house fires, car fatalities, critical injuries, terminal illnesses, divorce, even as victims of bullying and cyberbullying. Secondly, we must conclude that if both violent and non-violent situations can induce trauma, then perhaps it is not the situation that induces trauma but how that situation is being experienced that leaves children and youth vulnerable to trauma. If this is true, then it follows that we must first know how children are experiencing what they are exposed to if we want to determine what might be the most helpful and appropriate trauma-informed response.

The Experience Matters

Our premise that it is not the situation but how that situation is experienced that induces trauma is supported by resilience research, neuroscience, the proposed Developmental Trauma Disorder (DTD) and by traumatized children themselves who ought to be considered the best experts as to what helps and what hurts. Resilience research clearly documents that not everyone exposed to what we might consider to be a trauma inducing incident is necessarily traumatized by that incident (Bonanno, G., et. al., 2001). Assigning an appropriate intervention dictates that we first determine how children are experiencing what they are exposed to if we are to provide an intervention that itself is not traumatizing. In fact, the primary dictate of trauma-informed care is to avoid re-traumatizing, "to do no harm" (Hodas, G., 2006) by not making assumptions that children must be traumatized by what they have been exposed to or, if traumatized, that all children need the same intervention (Steele, W. & Raider, M., 2009).

During the past 20 years at The National Institute for Trauma and Loss in Children (TLC), children have taught us a very valuable lesson. They have let us know in a variety of ways that:

> *"If you don't think what I think…feel what I feel…experience what I experi-ence…see what I see when I look at myself, others and the world around me… how can you possibly know what is best for me?"*

This is a simple yet profoundly wise mandate. When we can appreciate how traumatized children are experiencing themselves, others and their lives as a result of their experiences, we can assign far more timely, useful and appropriate interventions. Ask two children exposed to the same situation what their biggest worry is since it happened, and you will often hear two different responses because each experienced that situation in different ways. One might say, "Does this mean the football game is cancelled?" while the other worries about who else might die. Each is experiencing what happened differently and will need different responses from us.

Again, this may appear to be an overly simple example of how we arrive at what constitutes trauma-informed interventions yet, knowing how children are experiencing themselves, others and their environment, represents the foundation on which we ought to select and apply our interventions.

Under-diagnosed/Misdiagnosed

It is well argued and supported by abundant research that traumatized children today are in fact going undiagnosed and misdiagnosed. Trauma symptoms are often mistaken for depression, attention deficit problems, oppositional defiant disorder (ODD), conduct disorder, reactive attachment and other disorders (van der Kolk, B. & Pynoos, R., 2009 a). This is due in part to our traditional focus on using symptoms as criteria for diagnosis, as well as the current, very narrow PTSD diagnosis found in the *DSM-IVTR* (APA, 2000).

In 2005 and again in 2010, Robert Pynoos, Bessel van der Kolk and their colleagues proposed a more relevant trauma category that reflects how traumatized children are presenting today and the abundant documentation neuroscience has provided regarding trauma's impact on the brain and body, behavior, learning and emotions. The proposed Developmental Trauma Disorder (DTD) is much more representative of how traumatized children experience themselves, others and the world around them as a result of their exposure to traumatic experiences (van der Kolk, B. & Pynoos, R., 2009 b). It also puts those experiences within a developmental perspective, which is infrequently discussed in the literature. How a divorce is experienced at age 6, for example, will be completely different than how it is experienced at age 16. Interventions will be different because of the developmental differences and experiences existing between these two age groups.

In listing the prescribed criteria for exposure, the proposed DTD is interested in the subjective experiences of children – the rage, betrayal, fear, resignation, defeat and shame. In other words, the experiences matter. TLC has always approached trauma as an experience not a diagnostic category. At that

time children were not yet included in the PTSD category, an inclusion that did not occur until 1994, but even then the added descriptions for children were limited (APA, 1994). The evidence-based *Structured Sensory Interventions for Children, Adolescents and Parents* (*SITCAP®*) programs of TLC address what it believes are the common experiences associated with trauma: fear, terror, worry, hurt, anger, revenge, guilt/shame, feeling unsafe, powerless and engaged in victim thinking versus survivor/thriver thinking (Steele, W. & Malchiodi, C., 2011). TLC interventions are therefore directed at these experiences and themes within a developmentally appropriate context.

In essence, a situation like divorce may not be violent, or traumatizing for many. However, even in a non-violent divorce – one void of physical abuse and threats of bodily harm – if the child's experience of that divorce involves terror, worry, guilt, feeling powerless, then that divorce may become traumatic. This is why intervention must relate to how the child is experiencing his world. One adolescent example is the teenage daughter who comes home in tears because her boyfriend left her. As a parent we are ready with the truth – "That's okay honey. There will be lots of other boyfriends who will have more to offer." This may be the truth, but such words, reasoning and logic will prevent that parent from connecting with their daughter, causing her to look elsewhere for support. In her world, she is in a lot of pain and believes at that moment that there will be no one else like her now ex-boyfriend. What she needs is for her parent to spend time in her world – a world of pain. She needs comforting and support. Healing begins when our responses match with the ways traumatized children are experiencing themselves and their world.

Obviously the world of the traumatized child is far more complex than presented in the above example. To identify practices that reflect the traumatized world children are living in and attempting to navigate, we need to define the primary experience of trauma and the impact it has on the brain, the body, behaviors, thoughts, and emotions.
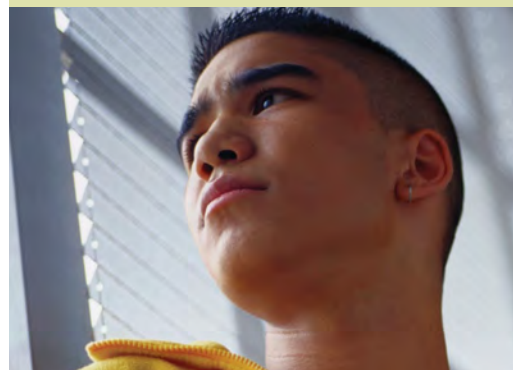
Assessment Outcomes Alone Not Enough

If we only completed an assessment of a traumatized child and found, for example, that trauma had created sensory integration challenges, we would have a basis for treatment. However, if we design that treatment without being aware of the kinds of experiences that child actually faced, the treatment may further traumatize that child. If for example, a weighted blanket is recommended as part of the sensory integration treatment to help calm that activated child, but the child has been sexually abused and the full weight of an adult on top of them was part of that experience, that treatment, that blanket and the sensation of heaviness, could in fact re-traumatize that child. Not having information about the details of the experiences associated with trauma places that child at greater risk when determining treatment. What then are the primary experiences of trauma, and subsequent implications for treatment and intervention?

Primary Experience of Trauma

When we say someone is experiencing grief, the one word that best describes that experience is sadness. When we say someone is experiencing trauma, the one word that best describes that experience is terror. We define terror as feeling totally unsafe and powerless (Steele, W. 2003 a). If this is what we experience then that loss is also likely to be traumatic. If the primary experience of trauma is feeling unsafe and powerless, it makes sense that interventions be directed at restoring that sense of safety and power. However, trauma is not primarily a cognitive experience and therefore "talk" alone is not likely to be helpful.

Implications for Treatment

Neuroscience has confirmed that trauma is experienced in the midbrain and lower brain, sometimes referred to as the "feeling" brain or the "survival" brain. Reason and logic, the ability to make sense of what has happened and act accordingly, simply are not accessible in trauma (Shore, A., 2001; Levine, P., & Kline, N., 2008; Ford, J., et. al., 2006; Perry, B., 2009; Brendtro, L., Mitchell, M., McCall, H., 2009). For this reason, we must direct our efforts at helping children with the experiences they are having, with the way they now see themselves, others and the world around them as a result of their exposure to trauma. We must engage them in experiences that allow them to "rework" their traumatic experiences and memories in ways that now allow them to see themselves as survivors and thrivers, others as help-

ful and supportive rather than threatening and unsafe, and life as promising rather than continually painful. Using talk therapy alone does not access that part of the brain where traumatized children are living and experiencing life.

Talking Alone Is Not Helpful

Practitioners often find purely cognitive behavioral interventions limiting and in some cases more traumatizing because traumatized children are driven by the sensory memories of their experiences, not reason and logic. Returning to the daughter who comes home in tears because her boyfriend has ended their relationship. This is an example of how the truth, how the reality that there will be other boyfriends, not only does not relate to what she is experiencing, but causes her further pain because we have failed to be with her in her pain as a result of how she is experiencing that loss. Trauma cannot be healed through cognitive processes alone because trauma is not a cognitive experience but, rather, a combination of feelings, sensations and images, iconic or symbolic memories that defy logic, reason, and attempts to talk one's way out of those reactions.

Neuroscience documents that children in trauma are governed predominately by the sensations associated with their traumatic memories – the sounds, smells, sensations of touch, and visual memories (NCTIC, 2011). When these senses are triggered or activated by similar sensations associated with a real or even a perceived sense of impending danger, they don't *think* but simply *act* on their senses. This is

why certain sounds, smells, environments, and even people and the way they present themselves can activate primitive survival responses. We may be very caring and skilled practitioners but, if one of our physical features is similar to the person who did that "bad thing" to that child, he cannot feel safe with us and will immediately rely on his survival responses. Reason and logic are overruled.

Survival Behaviors Driven by Experiences

Survival behaviors are also formed, driven and repeated because of how children experienced past traumatic situations and how they are experiencing their current situation, environment and people in their environment. If they feel unsafe, threatened or powerless, their trauma related survival behaviors may be activated. When children are direct victims of repeated trauma, like abuse, or exposed to multiple traumas, survival behaviors become more acute and include primitive, survival directed, fight, flight and freeze behaviors.

* *Fight behaviors can include verbal attacks, aggressiveness, assaultive behavior, and defiance.*

* *Flight responses can include running away, refusal to talk, avoiding previous relationships and activities, dissociation, numbing out, substance usage and abuse, eating disordered behaviors, depression, becoming suicidal and engaging in other at-risk behaviors.*

* *Freeze responses can include the inability to make decisions, unable to care for oneself, lethargy, non responsive, unable to interact or sustain relationships.*

At this moment, children need to experience something that is calming, soothing, familiar, safe; something they have engaged in previously that has allowed them to feel safe and in control and able to regulate their physiological, behavioral and emotional reactions. Talk rarely accomplishes this. Going to someone they feel safe with, going to a place where they feel safe, doing something they feel safe doing is what they need to experience in order to regain control and regulate their reactions. Once safety and a sense of empowerment is regained, talking about what happened may help reassure them.

We can then verbalize we are there to help them, not hurt them. We can clarify what happened and what or who activated their survival response, help them focus on the present and use this time as an opportunity to reinforce their strengths. Having access to multiple people they feel safe with, multiple safe places to go to, multiple activities that help them regain control and begin to regulate their reactions is essential in our efforts to help traumatized children, youth. Therefore, it becomes essential that the environment is trauma-informed, understands the survival needs of traumatized children and is able to provide the resources and opportunities for children to easily access who and what is safe and allows them to experience a sense of control (van der Kolk, B., 1996).

Thoughts Created by Experiences: Private Logic

The terror of 9/11 changed how we thought about ourselves as well as how we thought about others. It stripped away our secure sense of safety and our belief that our country was immune from such terror. In the days that followed, we did not think of ourselves as powerful and safe, but as vulnerable. As a result of this one thought, we began to behave differently. We were more suspicious of others, and more cautious. Perhaps we avoided larger events, even though not directly victimized as were those in New York, Virginia, and Washington DC.

Experiences do frame our thoughts (Adler, A., 1930). If you tell me you are a friend then hurt me, I will not think of you as a friend. My private logic regarding you becomes, "You are not to be trusted, you are not safe because of the experience I had with you." Traumatized children develop a complex list of thoughts, a private logic, as a result of their experiences. One example of the private logic that develops in children who have been abused is, "I will fight any person that I feel is a threat to me, any person who tries to control me because if I do not, I will be hurt again, and again and again."

Attempting to reassure a terrified child with words rarely helps. The traumatized brain especially when activated, will have a difficult time processing words, making sense of them or remembering what was said (Steele, W. 2003 b). Private logic is the result of what is experienced. It is going to be very difficult to change through cognitive interventions and verbal reassurance. It was created because of previous experiences, and will only be altered or replaced with a different logic as a result of new experiences.

The nature of the child's experience is at his core and therefore should be at the core of what guides us in determining what will be most helpful. Intervention must begin with experiences that meet the needs of traumatized children in their world. Those experiences must always be safe, empowering and directed at altering the way children view themselves, others and the world around them. For this to happen, experiences must be trauma-informed, address the major experiences of trauma and be structured in ways to influence changes in the thoughts and behaviors associated with trauma to those associated with being a survivor, a thriver, resilient and ready to flourish. TLC's *Structured Sensory Interventions for Traumatized Children, Adolescents and Parents* (*SITCAP®*) have demonstrated their ability to provide these experiences and accomplish these changes.

Short-Term Interventions, Long-Term Gains

Following are brief examples documenting the value of *SITCAP®* programs in reducing trauma-specific symptoms and related mental reactions through the use of its structured experiences. (Steele, W. et. al., 2008).

Repeated Abuse

Tables 1.1 and 1.2 show the significant reduction of trauma and mental health related symptoms of 15-year-old "R" who over a long period of time had been abused, neglected, and repeatedly raped before being removed from her drug-addicted parents. Two different standardized assessment tools demonstrate these statistically significant remarkable gains that helped change this youth from a victim to a thriver (Achenbach, T. & Rescorla, L., 2001; Briere, J., 1996).

Table 1.1 Case "R" Pre vs. Post Briere Trauma Symptom Checklist (TSCC-A)

Briere TSCC-A Scores	PRE	POST	3 MO*
Anxiety	9	2	1
Depression	14	3	3
Anger	22	5	4
Posttraumatic Stress	15	4	3
Dissociation	18	5	1

Table 1.2 Case "R" Pre vs. Post Achenbach Youth Self Report (YSR)

Achenbach YSR Scores	PRE	POST	3 MO*
Attention Problems	8	4	4
Rule Breaking Behavior	13	9	2
Aggression	13	11	3
Internalizing Behavior	15	4	3
Externalizing Behavior	26	10	1
Total Problems	63	23	20

* 3 month follow up post intervention

I Feel Better Now!

The *I Feel Better Now!* program *(IFBN)* was used to help 100 at-risk, multiply exposed, traumatized children in second through fifth grade not just feel better but do better at home and at school. In Table 2 (below) parents identified the changes they saw in their children one year after participating in the program. These outcomes reflect the significant gains thousands of children and teens experience yearly, who receive help from the TLC *SITCAP®* programs being used in schools, agencies and community programs throughout the country by our 6,000 TLC Certified Trauma Specialists (Raider, M., 2010).

PARENT TABLE 2 - One Year After *IFBN* Program

Parent Observations Group	
Improved Self-esteem	86%
Child talks more, more open with feelings	93%
Sleeping better	71%
No more nightmares	50%
Less Anger	71%
Fewer Arguments	71%
Better Grades	64%
Less nervous, jumpy, anxious	71%
Laughs more	71%

Domestic Violence

Tables 3.1 and 3.2 show the significant gains made by "S," a 12-year-old boy who witnessed the repeated abuse of his mother by his father and later his stepfather. Always living in fear ready for the next beating, "S" developed a number of trauma-specific and mental health related symptoms as shown in the tables below. He was failing in school and constantly fighting. By introducing him to new experiences via the *SITCAP®* intervention, his view of self, others and life changed, and his trauma-related behaviors diminished significantly.

Table 3.1 Case "S: Pre vs. Post Briere Trauma Symptom Checklist (TSCC-A)

Briere TSCC-A Scores	PRE	POST	3 MO*
Anger	9	2	2
Posttraumatic Stress	9	5	3
Dissociation	10	1	1

Table 3.2 Case "S: Pre vs. Post Achenbach Youth Self Report (YSR)

Achenbach YSR Scores	PRE	POST	3 MO*
Social Problems	7	0	3
Thought Problems	12	6	2
Attention Problems	12	3	2
Aggression	12	2	2
Internalizing Problems	16	2	1
Externalizing Problems	18	9	1
Total Problems	73	23	20

* 3 month follow up post intervention

TLC's *Structured Sensory Interventions for Traumatized Children, Adolescents and Adults* (*SITCAP®*) is a series of intervention programs for children 3-18 years of age, parents and adults. *SITCAP®* programs have been written about in numerous books such as *Understanding Mass Violence, Creative Interventions with Traumatized Children, Critical Incidents in Counseling Children*. Its research outcomes also are published in varied journals including, *National Social Sciences Journal, School Social Work Journal* and *Journal of Residential Treatment for Children and Youth*.

SITCAP® programs are now listed on the California Evidence-Based Clearinghouse and the Substance Abuse Mental Health Services Agency (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP). TLC research has repeatedly demonstrated that by giving traumatized children and youth the opportunity to address and "rework" the major experiences induced by trauma, their PTSD symptoms and related mental health reactions are significantly reduced, and the reactions to the challenges they continue to face become more resilient and indicative of posttraumatic growth (PTG).

The Distinguishing Difference

Because the focus on experience is such a key component for helping traumatized children over-
come the terror and pain of their traumatic lives, we wanted to determine what allowed some chil-
dren who participated in TLC programs to do better than others. In response, we conducted a formal
qualitative study (Steele, W., Kuban, C. & Raider, M., 2009) involving the children, their parents, and a
primary school social worker. We designed and conducted a number of focus groups to help deter-
mine how the children who did well perceived their parents, home environment and school, versus
those children who didn't respond as well.

Those who did well experienced the significant adults in their lives and their home and school en-
vironment differently than those who did less well. For example, those who did well could identify
multiple statements their parents repeatedly verbalized that made them feel good about themselves
and their parents, compared to generally indicating only one statement by those who did less well.
Those who did well experienced far more opportunities with their parent and peers. When asked
their favorite thing to do at home, those who did well described multiple experiences and activities
their parent involved them in at home, compared to those who did less well who cited sleeping and
watching television; in other words, they had limited experiences and interactions.

Those who did well also presented the following characteristics generally not experienced by those
who did less well –"I am important to someone – I am good at something – I can influence my world,
and I am a good person. "These children experienced a strong connection with a significant adult, a
sense of competency, a sense of empowerment in their ability to survive, and a sense of value in their
ability to influence the adults and the peers in their world. The legacy of those who do well is that
their experiences teach us how to help other children experience recovery and resilience for manag-
ing the future challenges they will face.

The following Experience of Recovery and Resilience Chart provides vivid descriptors of how trauma
victims began to re-experience themselves, others and their world following the help received from
TLC programs and services.

The Experience of Recovery and Resilience

THRIVER	• Life is bigger than just me now. • I have some new friends who are not survivors. • When I do think about it, I don't think about the horrid details but how it changed my life – each day is so important now. • The truth is, I never imagined I would be doing some of the things I'm doing now, the people I'm enjoying. • I enjoy having time for myself now…before I was too scared to be alone. • When some things happen to remind me, I now just think how fortunate I am compared to the way I was… • Change doesn't terrify me now…actually it's exciting at times. • Had all that stuff never happened, I would have never discovered how strong I am, but also how important it is to have other people in my life now.	• I can control my feelings now. • I really am positive about my life. • Routines are really important to me now. • Now I don't hesitate to ask for help. • I have a lot more compassion for others. • I certainly appreciate life more. • I'm making more choices about my life than I ever did. • I don't ignore or shy away from problems…I go right after them until they are worked out. • I really try to be of help to others now. • Sometimes I'm even surprised by my reaction to things happening…stuff happens and I move on, and it wasn't always like that. • I'm a lot more generous with my time.	**RESILIENCE**
SURVIVOR	• I no longer feel alone…I know others have had reactions like mine. • Things are making a bit more sense to me now. • It still hurts and scares me every now and then, but I'm no longer overwhelmed. • I can face the difficult memories head on now. • I am still surviving – I don't need to apologize for my behavior. • I am able to manage the day-to-day problems much better. • I hope nothing else happens but, if it does, I think I'll get through that, too. • There are some things I look forward to now. • Being with other survivors, I've learned I can help the new survivors coming to our group. • Everyday isn't great, but more days are a lot better now.	• I wake up and feel better now. • The hurt isn't all the time now…only when I think about … but even that isn't too bad. • I remember more of what people tell me now. • It's easier to pay attention…I'm not as jumpy. • My tears don't scare me so much now. • I'm not so scared, period. • There are days…but the tough times don't last as long now. • I used to worry a lot more about bad stuff happening…I don't worry as much. • I'm sleeping a bit more…I'm even laughing a bit more. • I go out with friends again…a little bit more.	**RELIEF**
TRAUMA VICTIM	• I can't stop thinking about… • Everything around me reminds me of… • I'm never going to feel safe again. • Why even bother? I can't change a thing. • It's all my fault…I should have… • I shouldn't have…If only I had… • It's never going to get better. • Why me?..Why now?...What next? • I close my eyes and see it all over again. • Everything makes me jump. • I can't think…I'm not remembering. • People talk to me, but I can't listen. • I'm ready to punch anyone. • I think about it, see images, even when I don't want to.	• I'm afraid to… • I worry about what next…Who next? • I have no energy. • I'm jittery. • I see our friend and start crying all over again. • I went to talk about it and started stuttering. • Her face, all those horrid details, they won't go away. • I still hear those sounds.	**TRAUMA VICTIM**

Summary
Experience –> Practice Expertise–> Research

We began our discussion by describing the primary experience of trauma and its implications for treatment. We continued discussing the critical importance of using traumatized children's experiences to guide us in our responses to them. We illustrated how practice intervention must involve experiences that allow traumatized children to experience themselves not as victims, but survivors; not powerless, but resilient. We supported this approach to healing traumatized children citing numerous resources and research.

At TLC we have always taken this position and have trained and certified over 6,000 Trauma and Loss Specialists across the country to put themselves in the position of being witnesses, curious rather than analytical. Engaging in this process they can experience what that child experiences as he looks at himself, others and the world as a result of his exposure to traumatic situations in his life. The intervention practices we teach are driven by the experiences of traumatized children and provide new experiences in ways that now allow them to experience themselves, others and the world with hope and resolve. These practices have undergone research in school, agency and community settings with children from a wide range of diverse cultures exposed to a wide range of multiple violent and non-violent trauma-inducing situations.

The response of this one parent and one practitioner summarize what thousands of other traumatized children, youth and professionals have experienced through The National Institute for Trauma and Loss in Children.

"Your program has absolutely changed my son's life. Every area of Michael's life has improved. Emotionally he is so much happier now, and he is doing great in school. This has given my son and me a life of hope. I can't thank you enough."
Bernadette N.

"I have been working with children for many years and am involved in supervising other clinicians and decided to use TLC's programs. The results were just so dramatic – it is a wonderful program for my own practice with traumatized children and will help our other clinicians as well."
Clotilde O'Keefe Lyons, Senior Clinical Psychologist
Southern Health Board, Kerry, Ireland.

For further information visit us at www.starrtraining.org/tlc or call 877-306-5256.

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